ATTACHMENT 4
ADA 2000 claim form completion instructions for dental services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Dentist's Pre-Treatment Estimate, Dentist's Statement of Actual Services, Specialty (not required)

Element 2 — Medicaid Claim, EPSDT, Prior Authorization # (required, if applicable)

EPSDT (HealthCheck): HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). If the services were performed as a result of a HealthCheck EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Elements 3-7 — Carrier Name, Carrier Address, City, State, ZIP (not required)

Element 8 — Patient Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Elements 9-11 — Patient's Address, City, State (not required)

Element 12 — Date of Birth (MM/DD/YYYY)

Enter the recipient's birth date in MM/DD/YYYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 13 — Patient ID

Enter the recipient's ***10-digit*** Medicaid identification number. Do not enter any other numbers or letters.

Elements 14-16 — Sex, Phone Number, Zip Code (not required)

Element 17 — Relationship to Subscriber/Employee (not required)

Element 18 — Employer/School (not required)

Element 19 — Subs./Emp. ID#/SSN# (not required)

Element 20 — Employer Name (not required)

Element 21 — Group# (not required)

Element 22-30 — Subscriber/Employer Name (Last, First, Middle), Address, Phone Number, City, State, ZIP Code, Date of Birth (MM/DD/YYYY), Marital Status, Sex (not required)

Element 31 — Is Patient Covered by Another Plan (not required)

Element 32 — Policy # (not required)

Element 33 — Other Subscriber's Name (required, if applicable)

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by commercial health insurance. Wisconsin Medicaid uses Element 33 to identify Medicare and commercial health insurance information, whether the recipient has commercial health insurance coverage, Medicare coverage, or both. Refer to Attachments 6-13 of this *Wisconsin Medicaid and BadgerCare Update* for the following information:

- Wisconsin Medicaid commercial health or dental insurance explanation codes for use in Element 33 (Attachment 6).
- Medicare disclaimer codes (Attachment 7).
- A key to Wisconsin Medicaid's seven commercial health insurance indicators for use when a recipient's eligibility is confirmed in EVS (Attachment 8).
- When the EVS indicates the code "DEN" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 9).
- When the EVS indicates the code "HMO" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 10).
- When the EVS indicates the code "VIS" for "Vision Only," providers are not required to bill private insurance.
- When the EVS indicates the codes "BLU," "WPS," "CHA," "HPP," or "OTH" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 12).
- When the EVS indicates the code "SUP" for "Medicare Supplement," providers must bill commercial insurance for Medicare-allowed services only (Attachment 11).
- Appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid (Attachment 13).

Recipients with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services

When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

Recipients with Medicare coverage

Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Do not enter a Medicare disclaimer code in Element 33 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. Refer to Attachment 7 for a list of Medicare disclaimer codes.

Recipients with both Medicare and commercial dental or health insurance

Use both a Medicare disclaimer code (e.g., "M-5") and other insurance explanation code (e.g., "OI-P") when applicable.

Element 34 — Date of Birth (MM/DD/YYYY) (not required)

Element 35 — Sex (not required)

Element 36 — Plan/Program Name (not required)

Element 37 — Employer/School (not required)

Element 38 — Subscriber/Employer Status (not required)

Element 39 — Subscriber/Employee Signature (not required)

Element 40 — Employer/School (not required)

Element 41 — Employee/Subscriber Signature Authorizing Payment (not required)

Element 42 — Name of Billing Dentist or Dental Entity

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 42 must correspond with the provider identification number in Element 44.

Element 43 — Phone Number (not required)

Element 44 — Provider ID

Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must correspond with the provider name indicated in Element 42.

Element 45 — Dentist Soc. Sec. or T.I.N. (not required)

Element 46 — Address

Enter the billing provider's complete street address. If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181), dated 09/02, to notify Wisconsin Medicaid that an address change has occurred. The form is located on the forms section of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 47 — Dentist License # (not required)

Element 48 — First Visit Date of Current Series (not required)

Element 49 — Place of Treatment

Enter the appropriate two-digit place of service (place of treatment) code for each service as indicated in Attachment 3.

Elements 50-52 — City, State, ZIP code

Enter the billing provider's complete city, state, and Zip code as they appear on the Medicaid certification letter.

Element 53 — Radiographs or Models Enclosed? (not required)

Element 54 — Is Treatment for Orthodontics? (required, if applicable)

Check yes or no to indicate whether or not the treatment is for orthodontics, and enter the date the appliances were placed if "yes" is indicated.

Element 55 — If Prosthesis (Crown, Bridge Dentures), Is This Initial Placement? (not required)

Element 56 — Is Treatment Result of Occupational Illness or Injury? (required, if applicable)

Check yes or no to specify if the dental services were the result of an occupational illness or injury. If "yes" is indicated, write a brief explanation in the space provided.

Element 57 — Is Treatment Result of: Auto Accident? Other Accident? Neither? (required, if applicable)

Specify if the dental services were the result of an auto accident or other accident. Write a brief description including dates if appropriate.

Element 58 — Diagnosis Code Index (not required)

Element 59 — Examination and Treatment Plans

Date (MM/DD/YYYY): Enter the date of service in MM/DD/YYYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth number or tooth letter is entered here. If the procedure applies to only one repair of dentures or partials, the area of the oral cavity is entered here.

Surface: Enter the tooth surface(s) restored for each restoration.

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter the appropriate procedure code and modifier for the dental service provided.

Qty: Enter the exact quantity billed. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.)

Description: Write a brief description of each procedure.

Fee: Enter the usual and customary charge for each detail line of service.

Total Fee: Enter the total of all detail charges.

Payment by Other Plan: Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 59 is greater than zero, "OI-P" must be indicated in Element 33.) Do not include the Wisconsin Medicaid copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows Wisconsin Medicaid to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier %: Not required by Wisconsin Medicaid.

Patient Pays: Not required by Wisconsin Medicaid. Do not enter recipient copayment amounts.

Admin. Use Only: Not required by Wisconsin Medicaid.

Element 60 — Identify All Missing Teeth With "X" (not required)

Element 61 — Remarks for Unusual Services (required, if applicable)

List any unusual services, including reasons why limitations were exceeded.

Element 62 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 62. The month, day, and year the form is signed must also be entered in MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with a date.

If Elements 42 and 44 indicate a clinic or group biller, indicate the Medicaid-certified performing provider's name and eight-digit Medicaid provider number in this element.

Elements 63-65 — Address Where Treatment Was Performed, City, ZIP Code (not required)